Output and information based requirements for Child Health Information Systems – comparison between 2012 and 2015 requirements
About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

The Information Requirements Specification (IRS) and the Output Based Specification (OBS) for Child Health Information Systems were initially published as two documents in 2012 by the Department of Health to support the commissioning and delivery of services.

The two documents have been updated and brought together into one document to improve the consistency of information in one source and avoid duplication. The revised document includes developments in the screening, immunisation, health and development requirements of children and young people which is reflected in national policy or statutory requirements that have emerged since its original publication in 2012:


This output and information based specification was published in March 2015 by Public Health England. This paper provides a summary of the high-level differences between the two versions of the document.
1. Screening

The 2015 version of the Output Based and Information Requirements Specification accommodates the extended new born blood spot screening programme to include; homocystinuria (HCU), maple syrup urine disease (MSUD), glutaric aciduria type 1 (GA1) and isovaleric acidaemia (IVA).

It also includes the requirement that infants up to and including three months of age who miss either optimal newborn examination within 72 hours or infant examination by eight weeks of age should have the examination undertaken as soon as possible.

It is also a requirement in the recent publication that CHIS should be able to report on all the data items as outlined in the Blood Spot Data specification.

In relation to newborn hearing screening all children should have had or have been offered a newborn hearing screen by three months of age. This included movers in from the other home countries, and from other countries.

2. Health Promotion

Commissioning responsibilities have been transferred to local authority commissioners from October 2015. All reviews are universally offered but may lead to a common assessment framework (CAF) being conducted, where information is based on CAF domains. From October 2015 five core stages of the Healthy Child Programme will be mandated and these have been included in the updated publication, which covers the initial antenatal assessment, the new baby review and the child development checks which should take place at six to eight weeks, at one year, and the two to two and a half year review.

The 2015 publication also includes the ASQ Ages and Stages questionnaire tool which can be used for developmental and socio-emotional review for children from one month to five and a half years. The CHIS needs to have the functionality to capture health promotion activity from all health and care contacts, including any optometry screening conducted prior to school entry.
3. Immunisation

The 2015 publication provides an update on the immunisation electronic interface requirements for all immunisation programmes. In particular it specifies that the CHIS system must allow the commissioning organisation to identify different population groups based on postcode to facilitate vaccine coverage estimates (resident populations, responsible populations eg school cohorts and GP registrations).

There is also an addition for the recording of relevant information of vaccines to include manufacturer, brand name, batch number, name of healthcare lead administering the vaccination, date administered and description of the vaccination site.

Further requirements are that the system must be able to record children who receive additional vaccinations due to being identified at clinical risk, eg children with asthma who are offered a flu vaccination. In addition the system should support any individual or once only nationally agreed immunisation schedules that require recoding, eg swine flu.

The system must be able to produce outputs of immunisation data as detailed in the PHE user guide to reporting to the COVER programme, which is referenced in the new ISN COVER standard. www.gov.uk/government/collections/vaccine-uptake

Immunisation against the rotavirus has been included in the immunisation programme for all children and pertussis for pregnant women.

There is also an additional requirement for CHIS functionality in that it needs to schedule and run catch up programmes, including for example, where children are not available for their initial vaccination date at school.

The chapter in the 2012 IRS/OBS on the information exchange between the National Child Measurement Programme and the CHIS has been removed to avoid confusion, as there are a variety of approaches taken by local authorities for this interface, and it was challenging to capture the breadth of these in the 2015 version. For example some local authorities may add measurement data directly into the CHIS and then extract and upload into the NCMP IT system, while others may load in the NCMP IT system and then extract and upload into their CHIS.

5. Intraoperability

The 2015 version has a renewed focus on the provision for child health information systems which should support extensive system interoperability to deliver the critical linkages between child health delivery systems, maternity records, the personal child health record (PCHR), the eRed Book, national screening systems, laboratories and GP practice systems in terms of communication of records and provision of failsafe processes. Therefore the revised document drives the move from paper to electronic processes by enabling data to be recorded once and shared reducing the opportunity for error and duplication.

This development includes the provision of a summary care record of child health information for export into other systems, including the development and consideration to support the integration of information arising from social services and educational information systems.

A further new interface requirement is that the system must support relevant messaging specifications in line with national messaging standards eg syncing of records with PDS, receipt of birth notification messages and support the receipt of demographic updates from National Health Applications and Infrastructure Services (NHAIS) via organisational links.
In addition the Child Health System population has also be revised and should include all children resident in an area, all children registered with a GP in the area and all children who are in schools within the area but are neither locally registered nor locally resident.

6. Maternity and Child Health Data Set (MCDS)

Information on child health is currently collated in differing systems on topics ranging from birth details, screening results and immunisation to growth measurements on school entry, breast feeding indicators and social care information. Correspondingly there is no current national aggregation of clinical data about child health.

The maternity and children’s dataset is a new dataset included in the output and information based specification, specifically developed for all NHS commissioned maternity child health and child and adolescent mental health services (CAMHS) as a key driver to achieving better outcomes of care for mothers, babies and children.

It comprises of three separate information standards:

Maternity Services dataset www.hscic.gov.uk/maternity

Children’s and Young People’s Health Services (CYPHS) dataset www.hscic.gov.uk/maternityandchildren/cyps

Children and Adolescent Mental Health (CAMHS) dataset www.hscic.gov.uk/maternityandchildrens/CAMHS

The MCDS has been developed to help achieve better outcomes of care for mothers, babies and children. This data set will provide comparative, mother and child centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities.
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The child health information system is required to have the functionality to collect and flow monthly data extracts on the data items in the Children’s and Young People’s data set to the Health and Social Care Information Centre.

Further information

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